

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1859

01848

Reg. Dist.

No. 191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Howard</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Howard</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Ellicott City</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Ellicott City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pine Orchard</b>				STREET ADDRESS (If rural, give location) <b>Pine Orchard</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <b>LINDA CAROLYN ADAMS</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 11, 1956</b> 19			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Feb. 8, 1944</b>	9. AGE last birthday: <b>12</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Ralph Adams</b>				14. MOTHER'S MAIDEN NAME: <b>E. ether Lavinka</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Mrs. E. ether Adams, Ellicott City, Md.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <b>Hydrocephalus - Spina B. fida</b>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <b>R. K. Fisher</b> DATE SIGNED <b>2/12/56</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>2-15-56</b>		NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>	
DATE REC'D BY LOCAL REG. <b>Feb. 15, 1956</b>		REGISTRAR'S SIGNATURE <b>John B. Loughran</b>		24. FUNERAL DIRECTOR <b>F. C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md</b>	
		<b>P. B. E. L.</b>					

BUREAU V. S.

FEB 20 1952

RECEIVED

## 1860 CERTIFICATE OF DEATH

Reg. Dist. No. 195

Item 3, Film G193 2-27-56 et

## 1. PLACE OF DEATH:

COUNTY

Howard

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)  
OR

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:  
(Type or Print)

Mollie Wille Eubank Baber

(Last)

(First)

(Middle)

(Last)

(Year)

DATE OF DEATH:

Month

(Day)

(Year)

## 5. SEX:

## 6. COLOR OR RACE

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT'S ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a) DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## INTERVAL BETWEEN ONSET AND DEATH

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work Not while at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/8, 1951, to 2/13, 1956, that I last saw the deceased alive on 2/13, 1956, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 21 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01850  
111

1861

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City Rural</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 Elloak</b>				d. STREET ADDRESS <b>Ellicott City Elloak</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS FREDERICK BLANEY</b>				4. DATE OF DEATH Month Day Year <b>Feb. 27 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1892</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Sanitary Commission</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Roger Blaney</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Schatz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-1007</b>		17. INFORMANT <b>Mrs. T.F. Blaney, Ellicott City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>nephrosclerosis with uremia 2 weeks</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>2/21, 1956</b> , to <b>2/27, 1956</b> , that I last saw the deceased alive on <b>2/26, 1956</b> , and that death occurred at <b>12:30 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>		ADDRESS (Street, city or town, state) <b>Clarksville, Md.</b>		DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>2/29/56</b>		24b. REGISTRAR'S SIGNATURE <b>John D. Laughman</b>	

CERTIFICATE OF DEATH

1961

DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE

TIME

CAUSE OF DEATH

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

PLACE OF DEATH

BUREAU V. S.

MAR 1 1966

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01851

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1862

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Howard</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Howard</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Ellicott City</b>				TOWN <b>Ellicott City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Shafers Convalescing Home</b>				STREET ADDRESS (If rural give location) <b>Mayfield</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>IDA M. BROWN</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 2, 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 12, 1891</b>	9. AGE last birthday <b>64</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clerical Work</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery Co. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lemuel Brown</b>				14. MOTHER'S MAIDEN NAME <b>Annie R. Biggs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>W.C. Brown, Ellicott City, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
491X IMMEDIATE CAUSE (A) <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Biliary Cirrhosis of liver</b>				1 year			
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1/6</b> , 19 <b>56</b> , to <b>2/1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/1</b> , 19 <b>56</b> , and that death occurred at <b>10:35 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>George E. Buehler</b> M.D.				ADDRESS (Street, city, town, state) <b>Ellicott City, Md.</b>		DATE SIGNED <b>2/3/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2-5-1956</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		LOCATION (City, town, or county) (State) <b>Alpha, Md.</b>	
24. REC'D BY REGISTRAR <b>John B. Loughran</b>		REGISTRAR'S SIGNATURE <b>John B. Loughran</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md.</b>	
DATE <b>Feb 5, 1956</b>							

Per. B. E. L.

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

01852

2411 N. Charles Street, Baltimore

## 1863 CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>SAME</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SAVAGE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SAME</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>58 WASHINGTON ST</u>		STREET ADDRESS (If rural, give location) <u>SAME</u>	
3. NAME OF DECEASED (First) <u>MINNIE</u> (Middle) <u>KEITH</u> (Last) <u>CONNER</u>		4. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE (MARRIED) WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <u>9 AUGUST 91</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
13. FATHER'S NAME <u>Thomas FRANKLIN PIERCE</u>		14. MOTHER'S MAIDEN NAME <u>CAMILLA FINKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS <u>DAUGHTER MRS FRANK BARNES - SCABESVILLE MD.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

1547 Immediate cause (a) <u>GENERALIZED CARCINOMATOSIS</u>	1 year
Antecedent cause(s) (b) <u>CARCINOMA OF RECTUM</u>	2 year
(c)	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>OCTOBER 1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>generalized metastasis over abdomen</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1955, to Feb 27, 1956, that I last saw the deceased alive on Feb 27, 1956, and that death occurred at 8:05 m., from the causes and on the date stated above.

SIGNATURE John R. Buell MD. (Degree or title) ADDRESS 402 Ivan St Laurel Md. DATE SIGNED 27 Feb 1956

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>March 2 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Harriarion Cemetery</u>	LOCATION (City, town, or county) (State) <u>Tom's Brook Virginia</u>
DATE REC'D BY LOCAL REG. <u>Mar 1 - 1956</u>	REGISTRAR'S SIGNATURE <u>Frank Shipley</u>	24. FUNERAL DIRECTOR <u>Dr. W. H. Canavan</u>	ADDRESS <u>Laurel Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955  
64  
1891  
1955

BUREAU V. B.

MAR 6 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

01853

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

1864

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <b>Howard</b>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Tridelphia Road</b>		STREET ADDRESS (If rural, give location) <b>Woodstock College</b>	
3. NAME OF DECEASED (First) <b>JOHN</b> (Middle) <b>WILLIAM</b> (Last) <b>ENGLE Jr.</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>27</b> (Year) <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>11-7-1893</b>
9. AGE last birthday <b>62</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Albertain, Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woodstock College</b>	
11. BIRTHPLACE (State or foreign country) <b>Albertain, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Engle</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Lutz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-05-4321</b>	
17. INFORMANT AND ADDRESS <b>Reno Engle, Daniels, Md</b>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Gunshot wound of chest</b>			<b>Instant</b>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b> (CITY OR TOWN) <b>Ellicott City (rural)</b> (COUNTY) <b>Howard</b> (STATE) <b>Md</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Feb. 27, 1956 8Pm.</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <b>Self Inflicted gun shot</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>George E. Higinbotham</b> (Deputy or title) <b>Deputy Medical Examiner for Howard Co.</b>		ADDRESS <b>Ellicott City, Md.</b> DATE SIGNED <b>2-27-56</b>	
RITUAL CREMATION (Specify) <b>Burial</b>		DATE THEREOF <b>March 1, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>good Shepherd</b>		LOCATION (City, town, or county) <b>Ellicott City, Md.</b> (State)	
DATE RETURNED BY LOCAL REG. <b>2/2/56</b>		REGISTERAR'S SIGNATURE <b>Alice H. Webb</b>	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct especially important. Physicians: please write the causes of death clearly and legibly

VS A15A

USE WITH

271



W. A. C. 100

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01854

## 1865 CERTIFICATE OF DEATH

Reg. Dist. No. 191

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Howard</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore Co.</u>		CITY <u>Ellicott City</u>		CITY <u>Catonsville 28.</u>	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		(If rural give location)	
X TOWN		<u>3 1/2 mos</u>		STREET ADDRESS		<u>21 Wyndcrest Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Willette MARIE Fitzsimmons</u>				<u>Feb. 18 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Nov 26, 1909</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>OWN HOME</u>		<u>Chicago, Ill.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM L. COLLIER</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>21 WYNDCREST AVE</u> <u>MILTON FITZSIMMONS CATONSD</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
440X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>				<u>6hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive CV Disease</u>				<u>month</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 9, 1956</u> to <u>Feb 18, 1956</u> , that I last saw the deceased alive on <u>Feb 18, 1956</u> , and that death occurred at <u>1:05 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur J. Michaeland</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Md. Taylor Manor Hosp. Ellicott City, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/21/56</u>		<u>NEW CATHEDRAL</u>		<u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>John B. Longman Jr.</u>		<u>Eastern Ave. Catonsville, Md.</u>			
DATE <u>Feb 18, 1956</u>							

B.E.L.

100-2401 V. E.

FEB 20 1964

REC-101

1866

## CERTIFICATE OF DEATH

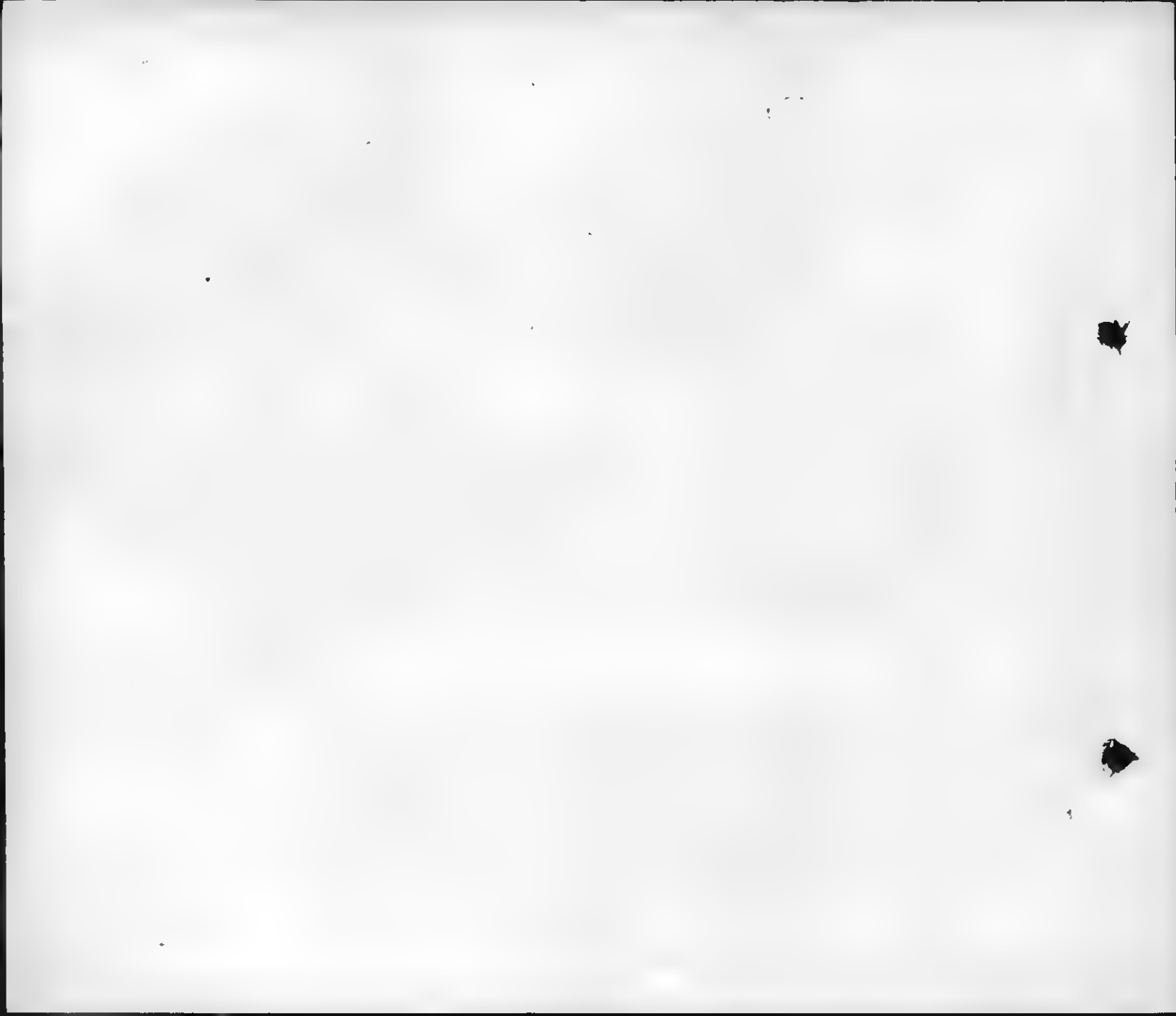
Reg. Dist. No.

190

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Essex</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		STATE <u>Md.</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>Life</u>		STREET ADDRESS (If rural give location) <u>5608 Washington Blvd.</u>		STREET ADDRESS <u>5608 Washington Blvd.</u>	
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
First: <u>Vera</u> (Middle): <u>Shirley</u> (Last): <u>Leppo</u>				Feb. 27 1956			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, OR DIVORCED: <u>Single</u>		8. DATE OF BIRTH: <u>Feb. 27, 1933</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday <u>23</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Carroll Co., Md.</u>	
13. FATHER'S NAME: <u>Oney Warfield Leppo</u>				12. CITIZEN OF WHAT COUNTRY? <u>Carroll Co., Md.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME: <u>Cathryn Groge</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT & ADDRESS: <u>Oney W. Leppo - 5608 Washington Blvd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 YR	
IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>							
ANTECEDENT CAUSE (B) <u>CARDIAC FAILURE</u>							
OISEAS OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>UREMIA, NEPHROLITIASIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE OIO (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July</u> , 1950 to <u>26 Feb.</u> , 1956, that I last saw the deceased alive on <u>26 Feb.</u> , 1956, and that death occurred at <u>4:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George E. Guleau</u>		M.O. <u>Chludge 27 ml</u>		DATE SIGNED <u>28 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/1/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Greenmount, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Hgts.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



01856

1867 **CERTIFICATE OF DEATH**

Reg. Dist. No. 191

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Howard</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Ellicott City</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Highland Manor Nursing Home</b>				STREET ADDRESS (If rural give location) <b>8638 Belair Road</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mr. John Link, Sr.</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 10th 19 56</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>May 18, 1870</b>		<b>9. AGE last birthday</b> <b>85 yrs.</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Tailor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Mr. John Adam Link</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Raymond C. Link, 1306 Churchhill Ave</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>446X</b> IMMEDIATE CAUSE (A) <b>Uremia</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Renal Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Generalized Arteriosclerosis</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>August 19 55</b> to <b>Feb. 19 56</b> , that I last saw the deceased alive on <b>2/8/56</b> , and that death occurred at <b>11am</b> , from the causes and on the date stated above.							
<b>ADDRESS</b> (Street, city, town, state) <b>5226 Baltimore National Pike</b>						<b>DATE SIGNED</b> <b>2/10/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/14/1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>John B. Loughran</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

**1**

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M

FEB

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01857

## 1868 CERTIFICATE OF DEATH

Reg. Dist. No. 191.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Howard</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Howard</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Ellicott City</b>				TOWN <b>Ellicott City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Waterloo Road</b>				STREET ADDRESS (If rural give location) <b>Waterloo Road</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>PHILLIP LOTZ</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 13, 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 1870</b>		9. AGE last birthday <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Lotz</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Repp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Spanish American</b>		17. INFORMANT & ADDRESS <b>Theodore Lotz, Baltimore, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>						<b>1 day</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Vascular Disease</b>						<b>4 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>				20. AUTOPSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2-12-56</b> , 19 <b>56</b> , to <b>2-13-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-12-56</b> , 19 <b>56</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>George E. Rungt</b> M.D.				ADDRESS (Street, City, town, state) <b>Ellicott City, Md.</b>		DATE SIGNED <b>2/14/56</b> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2-16-56</b>		NAME OF CEMETERY OR CREMATORY <b>St. Johns Lutheran</b>		LOCATION (City, town, or county) <b>Pfiffers Corner, Md</b>	
24. REC'D BY REGISTRAR <b>John B. Loughran, Jr.</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md</b>	
DATE <b>Feb. 15, 1956</b>							

B.C.L.

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W. A.

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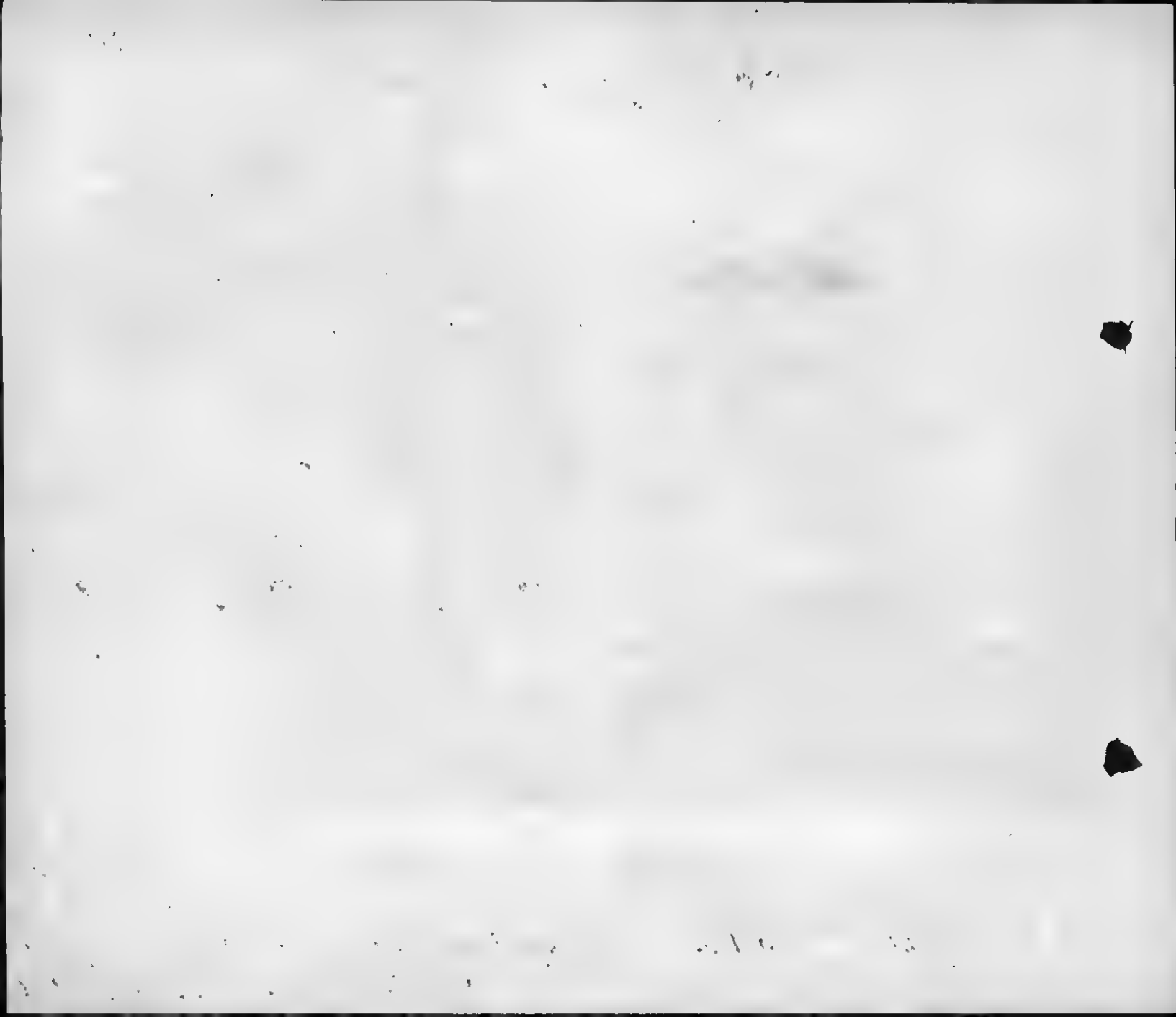
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Elkridge</u>		<u>2 1/2 yrs</u>		TOWN <u>Elkridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1923 St Augustine ave</u>				STREET ADDRESS (If rural, give location) <u>1923 St Augustine ave</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>C.</u>		(Middle) <u>andrew</u>		(Last) <u>Shaab</u>	
4. DATE OF DEATH:		(Month) <u>Feb</u>		(Day) <u>8</u>		(Year) <u>1966</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>June 14-1980</u>	
9. AGE last birthday: <u>75</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>author</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>State of Md</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore city</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>John Henry Shaab</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Cecelia Cooke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs Emily Regina Shaab, 1923 St Augustine ave, Elkridge, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
430: IMMEDIATE CAUSE (A) <u>Atherosclerosis</u>						4 days	
ANTECEDENT CAUSE (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary atherosclerosis</u>						2 mo	
						General Arteriosclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						1.72	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept, 1933</u> , to <u>Feb 8, 1956</u> , that I last saw the deceased alive on <u>Feb 7, 1956</u> and that death occurred at <u>2:35M</u> , from the causes and on the date stated above. <u>2/8/56</u>							
SIGNATURE <u>A. B. Brumblough</u>		M. D. <u>5609 main St Elkridge</u>		DATE SIGNED <u>27 Mar</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Augustine Cemetery, Elkridge, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR: <u>Feb 4, 1956</u>		REGISTRAR'S SIGNATURE <u>Wm. Cooke, Inc.</u>		24. FUNERAL DIRECTOR		ADDRESS <u>1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1870 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Elkridge (Rural)</u>		<u>2 1/2 yrs</u>		TOWN <u>Elkridge (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lawyers Hill Rd</u>				STREET ADDRESS (If rural give location) <u>Lawyers Hill Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Harriet Maria Warner</u>				<u>Feb 21 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan 16-1867</u>	<u>89</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Retired</u>		<u>Syracuse N.Y.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lewis Sulch II Edgar III</u>				<u>Harriet Maria Alvord</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>Huberta Warner Box 19 RD #4 Elkridge (Rural) 27 Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>clauformitis Stage</u>							<u>1 yr</u>
ANTECEDENT CAUSE (B) <u>chr Myocarditis</u>							<u>5 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>General arteriosclerosis</u>							<u>1 mo</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug, 1953</u> , to <u>Feb 4 1956</u> that I last saw the deceased alive on <u>Feb 21, 1956</u> , and that death occurred at <u>8:25</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W.B. Brumbaugh</u>		M. D. <u>5609 main st Elkridge 27 Md</u>		DATE SIGNED <u>2/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 25, 1956</u>		<u>Media Cemetery</u>		<u>Media, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 23, 1956</u>		<u>C. W. Hedrich</u>		<u>Henry W. Jenkins &amp; Sons Co.</u>		<u>4 York Road</u>	

MARGIN RESERVED FOR BINDING

No.	Name	Age	Sex	Occupation	Remarks
1	John Smith	25	M	Farmer	
2	Mary Jones	22	F	Homemaker	
3	Robert Brown	30	M	Teacher	
4	Elizabeth White	28	F	Shopkeeper	
5	William Black	35	M	Blacksmith	
6	Anna Green	20	F	Student	
7	James Grey	40	M	Physician	
8	Sarah Hall	24	F	Witch	
9	Thomas King	32	M	Minister	
10	Rebecca Lee	26	F	Midwife	
11	George Clark	38	M	Merchant	
12	Patricia Evans	21	F	Artist	
13	Richard Scott	33	M	Lawyer	
14	Julia Adams	23	F	Musician	
15	Henry Baker	45	M	Engineer	
16	Isabella Miller	27	F	Writer	
17	Charles Wilson	31	M	Scientist	
18	Frances Moore	29	F	Actress	
19	Samuel Taylor	36	M	Historian	
20	Elizabeth Young	25	F	Philosopher	

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01860

## 1871 CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH COUNTY <b>Howard</b> <b>Scaggsville,</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Scaggsville, Rural</b> <b>years</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Howard</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Scaggsville, Laurel, Md.</b> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <b>Hermann</b> <b>Gustav</b> <b>Wessel</b> (First) (Middle) (Last)			4. DATE OF DEATH <b>February 3,</b> <b>1956</b> (Month) (Day) (Year)				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>November 13, 1862</b>	9. AGE last birthday <b>93</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Kersensbruck, Germany</b>			
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Son: Mr. Herbert Wessel, Laurel, Maryland</b>			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>4231</b> IMMEDIATE CAUSE (A) <b>Hypo Static Pneumonia</b>					<b>1 week</b>		
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Myocarditis</b>					<b>years</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Arteriosclerosis</b>					<b>1 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>None</b>							
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>None</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/3/55</b> , to <b>2/3/56</b> , that I last saw the deceased alive on <b>2/3</b> , 19 <b>56</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city, town, state) <b>M.D. 402 Main St., Laurel, Md.</b>		DATE SIGNED <b>2/3/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 5, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>			
24. REC'D BY REGISTRAR <b>2/8/56</b>		REGISTRAR'S SIGNATURE <b>Mark Shipley</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>			
DATE		ADDRESS		FULTON, Maryland			

FEB 14 1955

RECEIVED